COMMUNITY HEALTH CONFERENCE ON HEART DISEASE IN COMMUNITY MEDICINE*

Morning Panel Discussion

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DR. MARGARET M. KILCOYNE. The variety of the presentations and the enthusiasm expressed for a new look at health care delivery in the United States has been impressive.

It was interesting to note that the delivery of health care is not exclusively a problem for a particular segment of the population, but rather that the aged, the young, the blacks, the whites, those in urban or in rural communities, those treated by private physicians or at hospital ambulatory care facilities—any of these patients may at some time have inadequate access to or fragmentation of health care. Further, active participation by the individual in understanding and preserving his own health has not reached optimal levels.

These matters have brought us together to ask one another questions in the hope of beginning to shape reasonable answers.

Questions have been submitted to the panel, and I have received one that is directed to all panel members. How does the medical profession intend to effect social change in the American life style? That might be the biggest question of all.

DR. ADRIAN M. OSTFELD. Let me start with a suggestion. Obviously it is a very difficult issue, but the fundamental truth of one fact remains.

*Held by the New York Heart Association at The Waldorf-Astoria, New York, N.Y., October 25, 1972.

The medical schools now, when they are trying to decide whom they are going to admit to medical school and whom they are going to refuse, make the decision almost entirely on the basis of intellectual characteristics, grades in school, and similar related values.

The criterion of being a decent, compassionate human being with regard for all people's problems somehow does not seem to be checked when we look at our applicants for medical schools. I think if we did look at these characteristics, we might begin to do a little bit better.

DR. KILCOYNE. There are several questions already in the hands of our panelists. I wonder if Dr. Hinkle would begin.

DR. LAWRENCE HINKLE. I have one question before me that has to do with the incidence of heart disease in blue-collar and white-collar workers, questioning the high incidence of heart disease in blue-collar workers. The general public's belief has been that it is otherwise. This is one of the prevailing myths of our time.

All of the data that I am aware of is generally consistent, as far as the urban population of the United States is concerned. It indicates that the incidence and prevalence of coronary heart disease and associated diseases is inversely related to the income and education of people in this population.

This may not be entirely true of groups in the lowest-level income or of others in some rural areas but certainly, as one ranges from the partly employed or part-time employed, semiskilled, blue-collar worker up to and through the white-collar, you find just what we found in the Bell System: that heart disease is a malady of the less well educated and the less well-to-do.

The explanation seems to be that the prevalence of hyperlipidemia and of hypertension, the frequency and duration of cigarette smoking, the shorter, stockier body builds, the evidence of hypertensive heart disease, and the evidence of diabetes, are all greater in the lower income and lower educated groups. This is just another one of those instances in which disease is more prevalent in the relatively less privileged members of the population.

I might make a comment on a point to which Dr. Ostfeld alluded: namely, the question of how one can improve the health of the American population.

We must remember that the delivery of health care is in the majority of instances the delivery of a service to a population that is already ill.

The delivery of medical care is a very important feature of medical activity. It is the activity that is primarily carried out by a physician, but it does not greatly improve the health of the population. In order to create a healthier population one has to create the circumstances under which people will grow up to be healthy, to live out full spans of life, to realize their latent biological and social potentials.

The maneuvers that create better health generally are a part of our over-all social activities. If I had to put my finger on the fundamental thing that one must do in order to create health, it would be to provide a more adequate income and education for those segments of our population which do not now receive them. If this is done, the effect over generations will, I think, be most important for our public health.

DR. PHILIP W. BRICKNER. I do not have any questions in front of me, but perhaps this gives me the opportunity to ask a question of Dr. Hinkle. Your material in regard to cigarette smoking referred to people smoking now. Do you have any information on how beneficial it is when people stop smoking?

DR. HINKLE. All the evidence is that, insofar as it relates to coronary heart disease and to sudden death, stopping smoking, even if one is in one's 50s and has smoked for a long time, is beneficial. Stopping smoking is one of the few acts I know of that is directly beneficial to the risk of death. Smoking in the past adds to the risk, but the risk of death goes down as one stops smoking, however long he had smoked before.

Stopping people from smoking is like stopping people from becoming obese. It is not easily done in middle life.

DR. KILCOYNE. I should like to ask Ms. Dumois to respond next.

Ms. ANA DUMOIS. I have a few questions. I shall answer the first two, which are related one to the other. They refer to the issue of hospital affiliation.

One asks: Would you consider any hospital affiliation adequate, or would affiliation with a medical center where there is ongoing education be the preferred affiliation? The next question is: What factors prevent hospital affiliation by doctors?"

I do not have to tell you that my answer is from a lay point of view. As to which hospital it is better to be affiliated with: first, I believe that affiliation with *a* hospital is better than affiiliation with *no* hospital.

Often, perhaps, we pay too much attention to affiliation with large medical centers with ongoing teaching programs. Actually there is evi-

dence that in large teaching hospitals physicians might be less compassionate and they might be looking more for the "interesting" cases to admit to the hospital.

I question whether affiliation with a big medical teaching institution is automatically better for the patient. I think it depends on what is going to be the impact on the tendency of the local practitioner to grant admission based on his judgment and to follow up once the patient is admitted.

Second, I think that we educate in all of our hospitals—municipal hospitals, voluntary hospitals, and private hospitals—and that we need a better system to control the quality of care rendered in every one of them.

Even in the best of medical school-affiliated hospitals these days we are not delivering adequate care for certain kinds of disease.

For example: we see in our emergency rooms, primarily at the hospitals with teaching programs, the least experienced men or women coping with the more acute crises such as the patient in heart failure or in another intense episode. There are situations in which seconds of delay or the wrong decisions might make the difference between life and death. So we must look at many factors other than whether or not the hospital has a teaching program.

In relation to the question of which factors prevent physicians from obtaining affiliation with hospitals, I have been able to identify the most important. One is the reason given by the medical profession itself: namely, the need to assure high-quality services at the hospital. Hospital administrators tell me that some physicians are not granted admitting privileges because they are not qualified enough to practice in their hospitals and they would not pass the qualifications set by the medical board of the given institution. This is what I am told by the majority of the medical boards and administrators where I have asked: "Why don't you accept physicians from the neighborhood?"

They say these physicians are not qualified to admit patients in this hospital. Well, they may not be qualified to admit patients to this hospital but they are qualified to treat patients outside the hospital. This is a good question that people must begin to raise. This is one of the reasons given as to why many physicians do not receive medical privileges in any hospital.

A second reason is that, according to some private physicians' opin-

ions, the great demand for their time made by the hospitals, as opposed to the time they are given for private practice, is so great that they prefer not to have affiliation privileges. I am told that this factor is now diminishing since the inauguration of Medicare and Medicaid because physicians are now generally paid for the hours given to the hospital.

A third reason is that physicians feel that when they bring patients into a school-affiliated hospital they lose control over their patients because they have to turn the care over to the house staff or to an intern or resident. Consequently some physicians are not enthusiastic about such "privileges."

Let me give you one example of the impact of quality care on community health. I have to mention the hospital in this particular case because I think it is important to begin to name such hospitals.

Some of you, I am sure, remember back in 1962 and 1963 when The Mount Sinai Hospital developed an affiliation with Elmhurst City Hospital in Queens. I had just come to this country at that time and the affiliation program had been presented as a panacea and the answer to the municipal-hospital situation.

The first thing that happened when Mount Sinai took over these professional services in Elmhurst was that the local doctors were dismissed from the hospitals. They continued treating patients in the community, of course, but they no longer had affiliation privileges at Elmhurst Hospital.

It was not because they were not capable. My hunch is that Mount Sinai had to make room for their interns, residents, and students, and consequently the local physicians could not continue practicing there.

The medical schools must examine carefully their responsibilities to the community. Yes, they have to train physicians, but if they train physicians by preventing people from getting care, I think their concern is misplaced. That is one of my concerns.

DR. OSTFELD. I have a number of questions here, and I shall try to combine them and answer them as quickly as possible. The first question is: How can I explain the fact that cigarette smoking has no effect in causing stroke in the elderly people whom we studied?

The answer to that, I believe, is that cigarette smoking is so deadly in younger groups that the people who were adversely affected by smoking did not survive long enough to get into our study.

The second question that I must ask is whether it is really true that

high blood pressure is much more of a problem for American blacks than it is for American whites and if so, why?

It certainly is. There is no question about it. One black American of every four over the age of 25 has high blood pressure.

There are three main theories that try to explain it. One is that blacks have greater amounts of salt intake in their diets because of eating frequently such items as salt pork, chitterlings, and pot liquor, which contain large amounts of salt. The other theory is that it is hereditary. The third theory is that it is sociocultural.

From my point of view the evidence is strongest that it is sociocultural and related to the black man's way of life in the United States. I believe that the evidence supporting the salt theory and the hereditary theory are not nearly so strong as those supporting the sociocultural theory.

Another question I have here is this: In people of middle age who have transient ischemic attacks or small strokes and who have high blood pressure and diabetes, can anything be gained by treating the high blood pressure and diabetes?

I am certain that much could be gained by treating the high blood pressure and bringing it down. The evidence that lowering high blood pressure will prevent stroke is very strong although, as Dr. Hinkle has pointed out, the evidence that lowering high blood pressure will prevent coronary heart disease is not very compelling. I believe that by lowering the blood pressure of people with high blood pressure, we can do much to eliminate strokes.

Diabetes is more complex. I am not so sure that careful treatment of diabetes will lead to favorable results.

DR. HINKLE. I agree with that.

I have a question which has to do with the prognosis of systolic hypertension as opposed to diastolic hypertension.

I think one can be too precious about this among people below the age of 45, let us say, who have hypertension which has not been treated, in whom, in most instances, both the systolic and diastolic levels are elevated. There are some people in whom the elevation is primarily systolic and others in whom it is primarily diastolic. These people all are at increased risk. As far as I am concerned, I do not think there is really convincing evidence that one is more important than the other.

The next question is a clinical question: How significant is the pres-

ence of paroxysmal atrial fibrillation in increasing risk factors in a 56-year-old male with a history of myocardial infarction 15 years ago?

When we begin to try to move from a statistical presentation to the discussion of individual patients we recognize that we must move with great care. One evaluates the individual patient in terms of all one knows about him.

I should simply say that, in terms of a population group, a man aged 56 who already has definite coronary heart disease and has a disorder of his cardiac rhythm is at increased risk of death as compared to a person with coronary heart disease who does not have a disorder of rhythm, and greatly at risk as compared to a person who does not have any coronary heart disease or any risk factors. But beyond that I should not want to go.

I have another question about the matter of blue-collar and white-collar background. It relates to middle-class habits. The question is: Does not the middle class eat a lot of saturated fats, especially beef, whereas the blue-collar class might exercise more than the middle class, and so on?

In point of fact, an excessive intake of fats and carbohydrates is widespread throughout the entire American population. Possibly it is more true of the blue-collar group than of the white-collar group. Slimness is more a feature of the well-to-do and well-educated. They are less inclined to indulge heavily in high-fat foods. I do not think it is true that the diet of the blue-collar group is better than that of the white-collar. Probably the opposite is true.

Also, you must recall that in our society at the present time high levels of caloric expenditure at manual labor have almost disappeared. It is disappearing even from among farm laborers. The average blue-collar man has a daily caloric expenditure that is not likely to be very much more than 3,000 kg. calories. The amount of manual labor he does may not be a great deal more than that of an office worker who exercises regularly.

The supposed protective factors do not actually operate for the blue-collar worker. As I have said before, it appears that the prevalence of obesity, diabetes, and hypertension increases in our society as one goes down the income and educational scale, except possibly at the very lowest level.

DR. BRICKNER. I have several questions in front of me. One is in

regard to medical and health services to the home-bound aged. In my talk I referred to the home-bound aged as one of several groups which are among the medically unreached.

At St. Vincent's Hospital we have plans which we are trying to get financed. We have learned that there are 2,000 to 3,000 home-bound aged within the neighborhood of the hospital, and that these persons do not receive care because they cannot get out of their homes.

To illustrate the difficulties of establishing programs, we have approached several governmental agencies with the hope of getting sufficient funds to purchase a vehicle and to pay the salaries of the driver and an assistant, with the assumption that the professional services would be donated. But to date we have been denied a grant because, as far as I can read between the lines, the agencies from whom we have requested funds do not feel that this is really a worthwhile service.

I expect, however, that we shall eventually prevail in getting this program established, and I hope that if we do it will be the forerunner of a number of such plans which might eventually cover the entire city.

Ms. DUMOIS. One of my questions reads: With regard to rheumatic fever, with the advanced information we have, why is this ailment not properly diagnosed and treated?

The other one says: In changing the health care services, what do you prescribe for reorganizing ambulatory care services so that delivery could become relevant to communities who wish it?

My biased answer to both is that the reason we are not getting the kind of diagnostic and treatment services that are possible with present knowledge is because we have left it up to the physicians. We have to educate our citizens so that they can hold the professionals accountable and begin to ask the necessary questions to make sure that the proper diagnostic procedures and treatments are followed.

I am convinced that until and unless people, all of us, realize that health is our business and not just the business of the health insurance companies and the professionals, that it is our business because it is our lives and our deaths that are in the balance, that we had better learn about it and try to find ways of making the health institutions accountable to us, and that until and unless we begin to try forcefully to get lay people to have more and more to say as to priorities, policies, and programs, we are not going to have any change in these systems.

And so my prescription is more involvement of all of us in trying

to see to it that it is the right of everyone not just to receive health care but to say what kind of care and what kind of program and how it is going to be delivered. That is my answer to the two questions.

DR. OSTFELD. Let me say briefly that I agree with the comments that Ms. Dumois has made, and I should add that if war is too important to be left to the generals, health is too important to be left to the physicians.

I have picked the toughest and most controversial question of the ones given to me perhaps because I feel foolhardy this morning. This question reads: Do you not feel that socialized medicine is a necessity here and now?

I am not at all sure that socialized medicine would have as much benefit as many other factors might be able to produce in this country. We have heard from the investigations of Dr. Hinkle that there seems to be an association between poverty and health, and this has been shown in many other studies, although often the studies that have shown it have not been as well controlled and as well carried out as Dr. Hinkle's.

The World Health Organization recently completed a study of several countries with good health statistics, and this study showed that the health of a country was more highly correlated with the income and education of its citizens that it was with the number of hospital beds.

Perhaps socialized medicine would not bring as much benefit as would, let us say, a guaranteed minimum annual wage, so that everybody could afford to buy the medical care which now is unavailable for many.